



STATE OF DELAWARE DEPARTMENT OF INSURANCE  
PREMIUM TAX AND FEES REPORT  
FOR THE CALENDAR YEAR 2005, DUE MARCH 1, 2006

Original Report ☐

Amended Report ☐

**FOREIGN**

**TAX DEPARTMENT MAILING ADDRESS AND COMPANY INFORMATION**

|                                   |  |  |      |  |
|-----------------------------------|--|--|------|--|
| Company Name:                     |  |  |      |  |
| Premium Tax Contact Person:       |  |  |      |  |
| Contact E-mail:                   |  |  |      |  |
| Tax Dept. Phone and Ext.:         |  |  | Fax: |  |
| Tax Department Address:           |  |  |      |  |
| City - State - Country - Zip + 4: |  |  |      |  |

|   |                          |
|---|--------------------------|
| Federal E.I.N. #:   |                          |
| N.A.I.C. #:   |                          |
| N.A.I.C. Group #:   |                          |
| State of Domicile (abbr.):  |                          |
| Has this Company written any Wet Marine and Transportation insurance in the United States in any of the past 3 years? (Check one) |                          |
| Yes   | <input type="checkbox"/> |
| No  | <input type="checkbox"/> |

IMPORTANT: If Company Name, Employer Identification Number (EIN), NAIC Number, NAIC Group, or any other Company Information changed during the year, you must complete the Historical Information Section on Page 4.

If this address or any other Company information changed during the calendar year, Check this Box → ☐

Was payment for these taxes and/or fees sent electronically via ACH Credit? (Check one)

|     |                          |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No  | <input type="checkbox"/> |

If claiming overpayment on Line 20, Check this Box → ☐

IMPORTANT: If claiming overpayment, DO NOT apply overpayment amount to quarterly tax liability. The State of Delaware will issue a refund check to Company.

\$

Pay amount listed on Line 19.  
Make check payable to "Delaware Insurance Dept."

NOTE: Authorization Agreement approval required for ACH Credit Option

**Form T-1 PREMIUM TAX SUMMARY FOR CALENDAR YEAR 2005**

**GROSS DIRECT PREMIUM INCOME** Must equal data reported on State Business Page (Statutory Page 14) of Annual Statement

|  |        |    |
|--|--------|----|
| 1. Life Premiums   | \$     | 1  |
| 2. Accident and Health Premiums  | \$     | 2  |
| 3. Property, Casualty, Surety and Title Premiums   | \$     | 3  |
| 4. Worker's Compensation / Employer's Liability Premiums   | \$     | 4  |
| 5. TOTAL - All Gross Direct Premium Income   | \$     | 5  |
| 6. Premium Tax Rate (2%)   | X .02  | 6  |
| 7. TOTAL Premium Tax eligible for Guaranty Fund Assessment Credit  | \$     | 7  |
| 8. LESS: Life & Health Insurance Guaranty Fund Assessment Credit   | \$ ( ) | 8  |
| 9. LESS: Property & Casualty Insurance Guaranty Fund Assessment Credit   | \$ ( ) | 9  |
| IMPORTANT: Guaranty Fund Credits may not reduce premium tax liability to less than zero.                                   |        |    |
| 10. NET Premium Tax Due (Line 7 less Line 8 and/or Line 9) Tax liability may not be < \$0.00. If less than "0", enter "0". | \$     | 10 |

**OTHER TAXES, FEES AND/OR CREDITS**

|   |                   |    |
|---|-------------------|----|
| 11. Domestic Insurer's Privilege Tax  | \$ NOT APPLICABLE | 11 |
| 12. Foreign Insurer's Retaliatory Tax and Fees  | \$                | 12 |
| 13. Employer/Trust Owned Life Insurance Premium Tax   | \$                | 13 |
| 14. Annual Continuation Fees (a) Certificate of Authority / Renewal Fee (RRGs enter \$50.00)                          | \$ 100.00         | 14 |
| (b) Annual Statement Filing   | \$ 100.00         | 14 |
| 15. Delaware Insurance Fraud Prevention Bureau Annual Fee (RRGs enter \$0.00)   | \$ 550.00         | 15 |
| 16. Credit Due from Travelink Program   | \$ ( )            | 16 |
| 17. TOTAL Taxes, Fees and/or Credits Due (Lines 10 thru 16)   | \$                | 17 |
| 18. LESS: Quarterly Tax Prepayments   |                   |    |
| a) April 15, 2005   | \$                |    |
| b) June 15, 2005  | \$                |    |
| c) September 15, 2005   | \$                |    |
| d) December 15, 2005  | \$                |    |
| e) TOTAL Prepaid during 2005 (Sum Lines 18a thru 18d)   | \$ ( )            | 18 |
| 19. NET AMOUNT DUE Attach payment for this amount. →  | \$                | 19 |
| 20. REFUND IMPORTANT: A Refund Check will be sent to the Company. DO NOT apply this amount to future tax liability. → | \$ ( )            | 20 |

## FOREIGN INSURERS' RETALIATORY TAX AND FEES INSTRUCTIONS

- Lines 1-3 List types and volumes of taxable premiums of insurance written in Delaware (as reported on Annual Statement State Page) at the applicable tax rate that your State of Domicile (Home State) would charge a Delaware domiciled insurer doing similar business in that state. Different types of insurance with the same tax rate may be combined and listed on one line. **Include all finance and service charges.**  
**DO NOT INCLUDE EMPLOYER/TRUST OWNED LIFE INSURANCE PREMIUM IN AMOUNTS LISTED ON LINES 1-3.** Employer/Trust Owned Life Insurance written in accordance with 18 Del. C., §2704(e) qualifies for exemption to retaliatory action as permitted in 18 Del. C., §532(b).
- Line 4 Workmen's Compensation/Employer's Liability premiums.  
**Note:** Workmen's Compensation premiums MUST be recorded separately on Line 4 (not combined and listed with other insurance).
- Lines 5-8 List Home State annual fees as applicable.
- Line 9 List number of new agents appointed in DE during calendar year. Multiply by Home State's appointment fee (list fee amount).
- Lines 10-11 List any and all miscellaneous annual fees that a Delaware domiciled company, writing similar lines and volumes of business would be assessed on an annual basis in your Home State. **Please describe and list each fee type separately.**
- Line 12 Home State Total – Sum Lines 1 through 11.
- Line 13 Delaware Net Premium Tax taken from Page 1, Premium Tax Summary, Line 7.
- Lines 14-15 Delaware annual Continuation Fees taken from Page 1, Premium Tax Summary, Lines 14(a) and (b). **DO NOT INCLUDE \$550.00 FRAUD FEE**  
**IMPORTANT:** The Delaware Insurance Department considers the Fraud Prevention Bureau Fee to be a Special Purpose Assessment and does not allow the fee amount paid to the State to be included in retaliatory tax calculation. (See [www.state.de.us/inscom](http://www.state.de.us/inscom) for more information)
- Line 16 Use the same number of new agents as listed in Line 9. Multiply by \$25.00 for Delaware basis calculation.
- Line 17 Delaware Total – Sum Lines 13 through 16. Subtract this amount from the Home State Total amount on Line 12.
- Line 18 **NET Retaliatory Tax** due to Delaware. Enter this amount on Page 1, Premium Tax Summary, Line 12. If "0", or less than "0", enter "0".

### Form T-3

### RETALIATORY TAXES AND FEES TAX CALCULATION

#### HOME STATE TAXES AND FEES

List State of Domicile (Home State): \_\_\_\_\_

|     | TYPE OF INSURANCE  | PREMIUMS               | TAX RATE | AMOUNT |    |
|-----|--|------------------------|----------|--------|----|
| 1.  |  | \$                     | @ %      | \$     | 1  |
| 2.  |  | \$                     | @ %      | \$     | 2  |
| 3.  |  | \$                     | @ %      | \$     | 3  |
| 4.  | Worker's Compensation  | \$                     | @ %      | \$     | 4  |
| 5.  | Certificate of Authority Renewal                                   |                        |          | \$     | 5  |
| 6.  | Annual Statement Filing Fee  |                        |          | \$     | 6  |
| 7.  | Annual Statement Abstract Fee                                      |                        |          | \$     | 7  |
| 8.  | Annual Statement Publication Fee                                   |                        |          | \$     | 8  |
|     | New Agent's Initial Appointments in Delaware during calendar year: |                        |          |        |    |
| 9.  | TOTAL # Agents   | @ Home State Fee of \$ |          | \$     | 9  |
| 10. |  |                        |          | \$     | 10 |
| 11. |  |                        |          | \$     | 11 |
| 12. | HOME STATE TOTAL (Sum of Lines 1 through 11)                       |                        |          | \$     | 12 |

#### LESS DELAWARE TAXES AND FEES

|     |  |                           |  |   |    |
|-----|--|---------------------------|--|---|----|
| 13. | Premium Tax  |                           |  | \$  | 13 |
| 14. | Certificate of Authority Renewal                                   |                           |  | \$  | 14 |
| 15. | Annual Statement Filing Fee  |                           |  | \$  | 15 |
|     | New Agent's Initial Appointments in Delaware during calendar year: |                           |  |   |    |
| 16. | TOTAL # Agents   | @ Delaware Fee of \$25.00 |  | \$  | 16 |
| 17. | DELAWARE TOTAL (Sum of Lines 13 through 16)                        |                           |  | (-) \$  | 17 |
| 18. | TOTAL Retaliatory Tax Amount Due (Line 12 minus Line 17)           |                           |  | Enter this amount on Page 1,<br>Premium Tax Summary, Line 12 \$ | 18 |

**REPORT OF GROSS PREMIUMS FOR  
STATE SUPPORT OF FIRE COMPANIES, AMBULANCE AND RESCUE ORGANIZATIONS**

**➤➤➤ THIS IS NOT A TAX ❄❄❄**

As with all forms in this tax report, the President and Secretary verify its accuracy and completeness.

- **Every company receiving premiums for insurance coverage in Delaware under the property and casualty lines listed, must complete Part I and Part II of this report. (18 Del. C., §705(a))**
- **Every company receiving premiums for life, accident or health insurance coverage of all types in Delaware must complete Part III of this report. (18 Del. C., §713)**
- **The State uses this information to determine the amount of financial support that volunteer fire companies and nonprofit ambulance and rescue services providers receive from the State.**

**INSTRUCTIONS**

**Form T-5**

**PART I:** Copy corresponding line number figures from State Page, [Exhibit Of Premiums And Losses (Statutory Page 14 Data)], page 26, Column 2

**PART II:** Each insurer **MUST** show what portion of the total gross direct premium listed in PART I is allocable to each of the four geographical sub-divisions within the state of Delaware. Allocations are to be determined by **location of risk**.

**Form T-6**

Line 1: Enter corresponding Delaware figure from Schedule T (page 62), Column 2.

Line 2: Enter amount listed on Page 4, Form T-8 Summary Form, Line 3

Line 3: Enter corresponding Delaware figure from Schedule T (page 62), Column 4.

**Form T-5**

**STATE SUPPORT OF FIRE COMPANIES**

**Based on Property and Casualty Premiums Written as Reported on State Page**

**PART I GROSS DIRECT PREMIUMS, LESS RETURN PREMIUMS BY LINE OF AUTHORITY**

|       |  |                |          |
|-------|--|----------------|----------|
| 1.    | Fire   | \$             | 1        |
| 2.1.  | Allied Lines   | \$             | 2.1      |
| 2.2.  | Multiple Peril Crop                                    | \$             | 2.2      |
| 2.3.  | Federal Flood  | \$             | 2.3      |
| 3.    | Farmowners Multiple Peril                              | \$             | 3        |
| 4.    | Homeowners Multiple Peril                              | \$             | 4        |
| 5.1.  | Commercial Multiple Peril (non-liability portion)      | \$             | 5.1      |
| 8.    | Ocean Marine (other than Wet Marine & Transportation)  | \$             | 8        |
| 9.    | Inland Marine (other than Wet Marine & Transportation) | \$             | 9        |
| 12.   | Earthquake   | \$             | 12       |
| 21.1. | Private Passenger Auto Physical Damage                 | \$             | 21.1     |
| 21.2. | Commercial Auto Physical Damage                        | \$             | 21.2     |
| 22.   | Aircraft (all perils)                                  | \$             | 22       |
|       |  | <b>→ TOTAL</b> | <b>T</b> |

**PART II PREMIUM DISTRIBUTION BY LOCATION OF RISK**

|  |  |         |    |
|--|--|---------|----|
| City of Wilmington                             |  | \$      | W  |
| New Castle County (outside City of Wilmington) |  | \$      | NC |
| Kent County                                    |  | \$      | K  |
| Sussex County                                  |  | \$      | S  |
| PART I TOTAL MUST EQUAL PART II TOTAL          |  | → TOTAL | T  |

PART I TOTAL MUST EQUAL PART II TOTAL

**Form T-6**

**STATE SUPPORT OF AMBULANCE AND RESCUE ORGANIZATIONS**

**Based on Life, Accident and Health Premiums Written as Reported on Schedule T**

**ALL GROSS DIRECT PREMIUMS**

|    |   |              |          |
|----|---|--------------|----------|
| 1. | Life (Do Not include Annuities)   | \$           | 1        |
| 2. | Employer/Trust Owned Life Insurance (Sum Total Delaware Premiums for all Cases) | \$           | 2        |
| 3. | Accident and Health   | \$           | 3        |
|    |   | <b>TOTAL</b> | <b>T</b> |

**Form T-7****TRAVELINK PROGRAM TAX CREDIT FORM**See Title 30, Del. C., §2030 ET SEQ for details.

As used in this section, TC is the amount of Tax Credit; CTG is the number of commuter trips generated, defined herein as the annualized number of employees reporting and departing from the place of employment during the peak travel periods; CTR is the number of commuter trip reductions, defined herein as the number of employees participating in a Delaware Department of Transportation Certified Travelink Program for at least 30 days of the applicable tax year; and DC is the employer's allowable direct costs. The credit granted under this law shall be the product of either equation described below; whichever is less. **Enter the amount from either Line 1 OR Line 2 on Page 1, Premium Tax Summary Form, Line 16.**

- |   |          |
|---|----------|
| 1. $TC + (CTR/CTG) \times DC$ <b>OR</b> | \$ _____ |
| 2. $TC + CTR \times \$250$              | \$ _____ |

**EMPLOYER OWNED/TRUST OWNED LIFE INSURANCE****Form T-8 SUMMARY FORM**

**Only companies writing this type of business as defined in 18 Del. C., §2704 should complete Form T-8 (see page 5.) Complete Form T-8 for each case. Sum the amounts from all cases for Lines 2, 5, and 6 on Form T-8 and transfer the total amounts from each Line to this Summary Form.**

- |   |          |
|---|----------|
| 1. TOTAL NUMBER OF CASES _____  |          |
| 2. TOTAL PREMIUM AMOUNT (Sum Line 2 for all cases)  | \$ _____ |
| 3. TOTAL DELAWARE PREMIUM AMOUNT (Sum Line 5 for all cases)      Enter this amount on Page 4, Part III, Line 2 →      | \$ _____ |
| 4. TOTAL PREMIUM TAX DUE (Sum Line 6 from all cases)      Enter this amount on Page 1, Premium Tax Summary, Line 13 → | \$ _____ |

**COMPANY HISTORICAL INFORMATION**

**Complete All Applicable Sections ONLY If There Was A Change During Calendar Year 2005.**

1. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer received **NEW** authorization to do business in the State of Delaware.
2. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer changed its **STATE OF DOMICILE** from the state of: \_\_\_\_\_ to the state of: \_\_\_\_\_
3. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer changed its **NAME** from its former name of: \_\_\_\_\_
4. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer changed its **E.I.N.** from: \_\_\_\_\_ to: \_\_\_\_\_
5. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer changed its **N.A.I.C. #** from: \_\_\_\_\_ to: \_\_\_\_\_
6. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer **acquired** Delaware business by way of *(circle one)* **Merger** or **Assumption Agreement** with another Insurer known as \_\_\_\_\_ NAIC #: \_\_\_\_\_
7. Effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_, the Insurer **ceded** essentially all Delaware business by way of *(circle one)* **Merger** or **Assumption Agreement** with another Insurer known as \_\_\_\_\_ NAIC #: \_\_\_\_\_ And further  
*(Check one)* \_\_\_\_\_ Remains an insurance corporation admitted in Delaware OR \_\_\_\_\_ Has surrendered its Delaware Certificate of Authority

➤➤➤ **ALL COMPANIES MUST COMPLETE THIS SECTION** ⬅⬅⬅

**AFFIDAVIT**

In accordance with 18 Del. C., §702 (a), the Premium Tax and Fees Report shall be verified by the oath or affirmation of the president or secretary or other responsible officer of the insurer, duly administered by a person authorized to administer oaths.

STATE of \_\_\_\_\_, COUNTY of \_\_\_\_\_, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the subscriber, personally appeared \_\_\_\_\_ (PRESIDENT), and \_\_\_\_\_ (SECRETARY) of the above named Insurer who being duly sworn (or affirmed) deposes and says that this report and all schedules are true, correct, and complete.

\_\_\_\_\_  
*Company Officer Signature*\_\_\_\_\_  
*Title*\_\_\_\_\_  
*Company Officer Signature*\_\_\_\_\_  
*Title**(Company Seal)*

If signed by Company Officer other than President or Secretary, state reason: \_\_\_\_\_

SWORN TO (OR AFFIRMED) AND SUBSCRIBED BEFORE ME THE DAY AND YEAR AFORESAID.

\_\_\_\_\_  
*Signature (Notary Public)*\_\_\_\_\_  
Date Commission Expires*(Notary Seal)*

**Form T-8****EMPLOYER OWNED / TRUST OWNED LIFE INSURANCE**

(Also Known As "COLI" and/or "BOLI", etc. Premiums)

**ANY COMPANY WRITING THIS TYPE OF BUSINESS AS DEFINED IN 18 Del. C., §2704 MUST COMPLETE THIS FORM****➤➤➤ ALL OTHER COMPANIES — DO NOT RETURN THIS PAGE <<<**

Complete this Form for each Employer/Trust Owned Life Insurance Case. After completion, sum the amounts from Line 2, Line 5 and Line 6 for all cases and transfer the total amounts from each Line to the Form T-8 Summary Form on Page 4. If company has more cases, reproduce Form T-8 or use a similar format and attach additional pages as needed.

|                         |   |                 |                   |
|-------------------------|---|-----------------|-------------------|
| 1.                      | Case Name:  | Case #:         |                   |
| 2.                      | Total Premium for this Case   |                 | \$                |
| 3.                      | Net Premium for risks located in Delaware   |                 | \$                |
| 4.                      | Net Premium for risks resident or located outside Delaware for which premium tax is not paid to the State of residency or location. |                 | \$                |
| 5.                      | Total DELAWARE Premium Amount for Calendar Year   |                 | \$                |
|                         | <b>PREMIUM AMOUNT</b>   | <b>TAX RATE</b> | <b>TAX AMOUNT</b> |
| <b>TAX CALCULATION:</b> | \$  | @ 2%            | = \$              |
|                         | \$  | @ 1.5%          | = \$              |
|                         | \$  | @ 1.25%         | = \$              |
|                         | \$  | @ 1%            | = \$              |
| 6.                      | TOTAL Tax Due This Case   |                 | \$                |

|                         |   |                 |                   |
|-------------------------|---|-----------------|-------------------|
| 1.                      | Case Name:  | Case #:         |                   |
| 2.                      | Total Premium for this Case   |                 | \$                |
| 3.                      | Net Premium for risks located in Delaware   |                 | \$                |
| 4.                      | Net Premium for risks resident or located outside Delaware for which premium tax is not paid to the State of residency or location. |                 | \$                |
| 5.                      | Total DELAWARE Premium Amount for Calendar Year   |                 | \$                |
|                         | <b>PREMIUM AMOUNT</b>   | <b>TAX RATE</b> | <b>TAX AMOUNT</b> |
| <b>TAX CALCULATION:</b> | \$  | @ 2%            | = \$              |
|                         | \$  | @ 1.5%          | = \$              |
|                         | \$  | @ 1.25%         | = \$              |
|                         | \$  | @ 1%            | = \$              |
| 6.                      | TOTAL Tax Due This Case   |                 | \$                |

|                         |   |                 |                   |
|-------------------------|---|-----------------|-------------------|
| 1.                      | Case Name:  | Case #:         |                   |
| 2.                      | Total Premium for this Case   |                 | \$                |
| 3.                      | Net Premium for risks located in Delaware   |                 | \$                |
| 4.                      | Net Premium for risks resident or located outside Delaware for which premium tax is not paid to the State of residency or location. |                 | \$                |
| 5.                      | Total DELAWARE Premium Amount for Calendar Year   |                 | \$                |
|                         | <b>PREMIUM AMOUNT</b>   | <b>TAX RATE</b> | <b>TAX AMOUNT</b> |
| <b>TAX CALCULATION:</b> | \$  | @ 2%            | = \$              |
|                         | \$  | @ 1.5%          | = \$              |
|                         | \$  | @ 1.25%         | = \$              |
|                         | \$  | @ 1%            | = \$              |
| 6.                      | TOTAL Tax Due This Case   |                 | \$                |

➤ Each case must be reported. This Form may be reproduced. Attach additional pages as needed. <